Maine HIV/AIDS Demonstration

FACT SHEET

Name of Section 1115 Demonstration:	Maine HIV/AIDS Demonstration
Date Proposal Submitted:	November 9, 1998
Date Proposal Approved:	February 24, 2000
Proposed Implementation:	July 1, 2002
Date Proposal Ends:	June 30, 2007
Date Amendment Submitted:	August 16, 2002
Date Amendment Approved:	January 17, 2003

SUMMARY

On October 30, 1998, Maine submitted a section 1115 proposal to provide a limited set of Medicaid benefits to individuals with HIV/AIDS who would not otherwise be eligible for Medicaid. The proposed demonstration will expand access to those without health insurance, allow individuals to become eligible for treatment through the demonstration without having to spenddown, and also allow individuals to be involved in gainful activity. This expansion population would include individuals with HIV/AIDS with a gross family income up to 300 percent of the Federal Poverty Level (FPL). The intent of the demonstration is to provide more effective, early treatment of HIV disease by making available a limited but comprehensive package of services, including anti-retroviral therapies. The State believes that early treatment and case management services provided to individuals with HIV/AIDS would reduce expensive hospitalizations and improve the quality of life for individuals who are able to enroll in the demonstration. Individuals who enroll in the demonstration would be responsible for payment of monthly premiums and service copayments. The State would like to limit the number of individuals who enroll in the demonstration, and would adopt a waiting list function, if necessary.

ELIGIBILITY

The State revised its proposal to include in the demonstration individuals who are HIV positive and whose family income is at or below 250 percent of the Federal Poverty Level (FPL). The demonstration will expand access to those without health insurance, allow individuals to become eligible for treatment through the demonstration without having to spenddown, and also allow individuals to be involved in gainful activity. Individuals who, through the course of the

demonstration, become eligible for non-demonstration Medicaid will be enrolled in the non-demonstration Medicaid program.

Requirements to receive benefits under this demonstration are as follows:

- Positive HIV status
- Financially eligible
- Willingness to sign informed consent that includes
- Understand requirements of the benefit
- Willingness to comply with treatment recommendations
- Complete information sheet relating to other insurance (TPL)
- Payment of premiums (if applicable)

BENEFIT PACKAGE

The benefit package of services includes:

a) All medications covered by Medicaid;
b) Physician services;
c) Laboratory and x-ray;
d) Case management services;
e) Ambulance;
e) Transportation (to covered services);
f) Hospital services;
g) Mental health and substance abuse services

COST-SHARING

There are co-payments of $10 for physician office visits and for each prescription. Participants under age 21 are exempt from these co-payments. All other Medicaid co-payment rules apply. For individuals above 150% of FPL will be required to pay premiums that are tiered based on income and will rise 5% annually.

ENROLLMENT

Based on financial requirements including a spending cap, enrollment for the first year is estimated to be able to include 130 enrollees. If enrollment reaches the ceiling, individuals will be placed on a waiting list. The Bureau of Medical Services will work with CMS personnel prior to implementation of any changes if it is anticipated that the enrollment cap or FPL ceiling could be raised or lowered.

DELIVERY SYSTEM

Services for the demonstration would be provided under a fee-for-service delivery model. All services will require prior authorization and will be ordered and prescribed by the physician.

Participants will be permitted to choose among participating providers (agencies).

Individuals with other insurance may be members of this benefit. The Bureau of Medical Services may pay premiums/cost-sharing for this insurance according to current State Medicaid rules.

QUALITY ASSURANCE

The Bureau of Medical Services (BMS) intends to model, as a key feature of this demonstration, how decision support can enable physicians, case managers and other allied health professionals to better manage care through regular and timely access to patient information. BMS will be prepared to analyze and process pharmaceutical data on a timely basis, for example, and provide patient specific feedback to physicians and case managers. In addition, since guidelines regarding HAART therapy are updated constantly BMS intends to work closely with its core group of providers with large HIV/AIDS patient caseloads to assess when guidelines should be modified and distributed to all providers across the State. As well, BMS contracts with Goold Health Systems to perform Drug Utilization Review (DUR) and share relevant information to treating physicians to better support the quality of care delivered through their practice. BMS has had positive experiences in those instances when it has shared with physicians the difference between the experience of individual Medicaid patients and established drug-prescribing standards. Assumptions about what is optimal for each individual's patients will be established as regular dialog occurring during the decision support and drug utilization review process.

Other features of this demonstration project will include the use of specialized pharmaceutical edits and audits for both Medicaid HIV waiver and non-waiver Medicaid patients. Specialized edits will occur, live at the pharmacy, at the time drugs are dispensed. Pharmacists will be asked to review drug orders to monitor those instances when drug-drug combinations should not occur, are not generally recommended, such as when it is know that a drug effect is not likely to be sustained so as to prevent adverse or undesirable drug-drug interactions right up front.

It is anticipated that system support will regularly query patient information in order to monitor such things as optimal levels and timing of viral load testing. For example, clear guidelines have been established for the regular testing of patients at the time of a change in drug combinations and at regular intervals to measure the effect of the drugs and to monitor for any adverse side effects related to drug-drug and/or drug-disease interactions. Decision support will monitor patient information and share with individuals physicians discrepancies between the experiences of individual Medicaid patients and those established guidelines. The Clinical Advisory Committee and the DUR committee will inform decision support as to the known probability of side effects associated with any given drug, or disease state, or for patients on investigational drugs, or for patients with specific conditions such as CMV retinitis. The Clinical Advisory Committee will further advise the Bureau on how to develop queries as well as advise on testing for physicians in order to minimize adverse drug effects.

Audits will occur at least monthly. Audit criteria will reflect some themes such as the concerns about

how some drug-drug combinations may present long term side effects or the known probabilities around dug-disease interactions. This information will be offered to individual physicians so that they may weigh the pros and cons of their patients being on a drug at any given time.

Full compliance with optimal drug treatment cannot be mandated, but with enough resources placed into system support for this program, we expect to achieve near 100% compliance based on reasonable exceptions. The Bureau of Medical Services intends to measure and improve adherence to optimal individual regimens by improving lines of communication and supplying timely and reliable treatment data to providers and case managers. To the extent that physical compliance of optimal drug therapies is possible, BMS believes that decision support will represent a significant system support.

MODIFICATION

On August 16, 2002, the State submitted a request to the terms and conditions to allow providers to refuse service delivery to 130 uninsured persons in the demonstration that do not pay the co-payment. This would affect the $10 co-payment for pharmacy and physicians services. This amendment request was approved on January 17, 2003.

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